

COORDINATION OF BENEFITS QUESTIONNAIRE

PLEASE COMPLETE THIS SECTION ONLY IF YOU OR ANY MEMBER OF YOUR FAMILY HAS OTHER THAN GHI INSURANCE COVERAGE			
PART C: OTHER INSURANCE INFORMATION			
Note: If more than one other insurance policy is in effect please list below all other insurance coverage available.			
Name of person who is the subscriber, insured or policy holder of the other insurance			
Name(s) of the company/union or employer providing the other coverage			
Address			
City	State	Zip Code	Phone Number ()
Name of Insurance Carrier			Insurance Carrier's Phone Number ()
Policy/Group Number	Effective Date of Coverage (mm/dd/yy)		
Contract Type:			
<input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Parent/Child <input type="checkbox"/> Husband/Wife <input type="checkbox"/> Other			
MEDICARE COVERAGE			
Are you, or any member of your family covered by Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO			
If yes, please complete the following:			
SUBSCRIBER'S INFORMATION		SPOUSE or FAMILY MEMBER'S INFORMATION	
Medicare Number	Medicare Number		
Effective Date Part A	Effective Date Part A		
Effective Date Part B	Effective Date Part B		